Michigan Department of Consumer & Industry Services
Bureau of Health Services
P.O. Box 30670
Lansing, MI 48909
517-335-0918
Fax 517-373-2179
TTY 517-373-7489

OHS/HLD-003 (4/03)

Board Use Only

DATA CHANGE/DUPLICATE LICENSE REQUEST

Authority: Public Act 368 of 1978, as amended.

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

PHARMACY STORES AND MANUFACTURER/WHOLESALER/DISTRIBUTORS MAY NOT USE THIS FORM FOR A NAME OR ADDRESS CHANGE. CONTACT THE BUREAU OF HEALTH SERVICES AT (517) 335-0918 TO REQUEST A RELOCATION APPLICATION.

Current Name on License/Registration _____
Last First Middle

Please state profession(s) you are requesting to be changed:

Profession: _____

MI Permanent I.D. Number: _____

Date of Birth	Phone Number	U. S. Social Security Number

Please specify which licenses/registrations you want changed. **NO CHANGES WILL BE MADE IF THIS FORM IS NOT COMPLETE**

- ☐ **Professional License/Registration**
- ☐ **Specialty License**
- ☐ **Controlled Substance**
- ☐ **Drug Control**
- ☐ **Additional Location Controlled Substance**

Please check the boxes below for the service you are requesting:

☐ 1. **NAME CHANGE**: I request the Department to change my records due to a name change. Signature must be provided on reverse side. If you would like a new license reflecting your new name, please see fee requirement on reverse side.

New Name: (Print Clearly) _____
Last **First** **Middle**

Reason for Change: _____

☐ 2. **ADDRESS CHANGE: FOR PROFESSIONAL AND/OR SPECIALTY.** I request the Department to change my record due to an address change.

Address: _____

_____

City, State and Zip Code: _____

The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name:

☐ 3. **ADDRESS CHANGE: FOR CONTROLLED SUBSTANCE AND DRUG CONTROL LICENSE**

MI Permanent I.D. Number: _____

I request the Department change my records due to the address change. If additional controlled substance licenses need changing, please send a request for each one.

Name of Facility or Office: _____

Address: _____

City, State and Zip Code: _____

4. **DUPLICATE LICENSE**: I request the Department to issue a duplicate for the following reason:

☐ Data Change (Complete Front Side) ☐ Lost ☐ Stolen ☐ Not received ☐ Destroyed

Please check **below** which one(s) you want duplicate licenses issued for. Make your check payable for the total amount.

☐ Professional License/Registration - $10.00 ☐ Specialty License - $10.00 ☐ Controlled Substance - $10.00

☐ Drug Control - $10.00 ☐ Additional Controlled Substance - $10.00

You will not receive notification of the change(s). You can check our web site after two weeks to confirm the change. http://www.cis.state.mi.us/free

Signature:	Date: